Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 32/16

I, Sarah Helen Linton, Coroner, having investigated the death of ***Hayder SAYED*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***14 September 2016*** *find that the identity of the deceased person was* ***Hayder SAYED*** *and that death occurred on* ***22 August 2010*** *at* ***Curtin Detention Centre, Derby****, as a result of* ***acute cardiac failure in association with severe ischaemic heart disease secondary to severe coronary atherosclerosis*** *in the following circumstances:*

Counsel Appearing:

Ms A Sukoski assisting the Coroner.

TABLE OF CONTENTS

INTRODUCTION

1. Hayder Sayed (the deceased) died suddenly from heart failure on 22 August 2010.

2. At the time of his death the deceased was in immigration detention, having been held at Curtin Immigration Detention Centre (Curtin IDC) in Derby, Western Australia until he collapsed on 21 August 2010 and was rushed to hospital. He was held in detention because he was reasonably suspected by officers of the Department of Immigration and Citizenship (now known as the Department of Immigration and Border Protection) to be an unauthorised maritime arrival and an unlawful non-citizen under the *Migration Act 1958* (Cth). He had been served with a detention notice under s 89(3) of the *Migration Act 1958* on 22 May 2010 at Flying Fish Cove, Christmas Island after arriving there by boat. He was later transferred to Curtin IDC on 2 August 2010.[1]

3. Under s 22(1)(a) of the *Coroner's Act 1996* (WA) (the Act) a coroner who has jurisdiction to investigate a reportable death[2] must hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death 'a person held in care.' A person held in care is defined to mean, effectively, a person involuntarily detained under certain Western Australian legislation, including the *Prisons Act 1981* (WA).

4. A person held in immigration detention under the *Migration Act 1958* does not come within the definition of a person held in care, so there was no requirement for me to hold an inquest. However, given that the deceased was, nonetheless, involuntarily detained, it was desirable that an inquest be held.

5. I held an inquest at the Perth Coroner's Court on 14 September 2016. The focus of the inquiry was the medical care provided to the deceased while in immigration detention.

6. The documentary evidence adduced at the inquest comprised two volumes of evidence,[3] including a comprehensive report of the death prepared by the Western Australia Police and relevant documents provided by the Department of Immigration and Border Protection (the Department). Oral evidence was provided by Mr Michael Shelton from the Department, Sergeant Heather Carter from the WA Police and Dr Michael Davis, an expert cardiologist.

---

[1] Exhibit 1, Tab 11.
[2] As defined in s 19 of the Act.
[3] Exhibits 1 and 2.

THE DECEASED

7. The deceased was born on 1 January 1980 in Afghanistan. He had moved to Pakistan at some stage and lived with his wife and two children in the remote village of Quetta in Pakistan. He had no formal education and worked as a shopkeeper in an electrical shop that sold surveillance equipment prior to coming to Australia.[4]

8. The deceased had no relatives in Australia but reportedly chose to come here "to escape a bad situation."[5] He made his way to Australia on a boat called the "Nakara" intending to seek asylum. The boat was intercepted by an Australian Customs Vessel on 18 May 2010 south west of Ashmore Islands. The boat was escorted to Christmas Island and the deceased disembarked on 22 May 2010.

9. On April 2010 the Australian Federal Government had announced a suspension on the processing of all new applications from asylum seekers from Sri Lanka and Afghanistan. As a result, no assessment was made by the Department of the deceased's asylum claims. The suspension was later lifted on 30 September 2010, after his death.[6]

MEDICAL SCREENING & CARE AT CHRISTMAS ISLAND

10. Health services in immigration detention centres are contracted by the Department to International Health and Medical Services (IHMS). On his arrival at Christmas Island the deceased underwent a Health Inductions Assessment by IHMS staff, the physical component of which detected no abnormalities, although the records show he was hypotensive (low blood pressure) and clearly underweight, with a BMI of just 18.42.[7] He provided no significant prior medical history and, in particular, no record of a previous cardiac event.[8]

11. During the mental health examination component the deceased disclosed that he took diazepam medication for sleep issues, but he had not done so for the past month. He was then provided with mirtazapine medication to assist with insomnia.[9]

---

[4] Exhibit 1, Tabs 8, 12 and 43.
[5] Exhibit 1, Tab 43, Mental State Examination Assessment.
[6] Exhibit 1, Tab 13.
[7] Exhibit 1, Tab 9, p. 1 and Tab 14.
[8] Exhibit 1, Tab 9, p. 1.
[9] Exhibit 1, Tab 14 and Exhibit 2, Tab 2.

12. On 15 June 2010 the deceased was diagnosed with conjunctivitis and was provided medication for this condition.[10]

13. On 1 July 2010 an IHMS nurse noted that abnormalities were detected on the deceased's chest x-ray. The deceased did not attend repeated appointments booked for 2, 6, 7, 9, 12, 13, 14 or 16 July 2010 to discuss these findings with an IHMS general practitioner, although he apparently did attend regularly for his nightly medication.[11]

14. Mr Michael Shelton, the Director of Onshore Health Operations for the Department, explained at the inquest that the Department tries to "encourage detainees' self-agency"[12] and as part of that philosophy detainees are encouraged to be proactive in managing their own health. Accordingly, whilst appointments are made for detainees and they are given information about where and when to attend, just like in the community they are not required to attend medical appointments and have the right to decline medical treatment.[13]

15. On 21 July 2010 the deceased finally attended an appointment with an IHMS GP, Dr Peter Cardon, to discuss the chest x-ray results. Dr Cardon had not seen the deceased before but was aware the appointment was in order to review the deceased's condition in relation to the chest x-ray, which reported a slight enlargement of the heart shadow, with a suggestion by the reporting radiologist to give consideration to pericardial effusion (excess fluid around the heart). Dr Cardon noted there were signs of old tuberculosis but none of active tuberculosis that might have caused effusion and enlargement of the heart shadow.[14]

16. Dr Cardon reviewed the deceased with the assistance of an interpreter and established that the deceased was a heavy smoker who exhibited shortness of breath on exertion and brief episodes of dizziness on rising. He did not give a history of chest pain. The deceased had slightly low blood pressure and his dizziness was characteristic of postural hypotension, which was consistent with his low body mass, tropical heat and fluid depletion. He showed no overt features of heart or lung disease. No need for treatment was indicated at that time but he was advised to quit smoking. As a precaution, Dr Cardon made an appointment for the deceased to be re-examined by a doctor in two weeks.[15]

---

[10] Exhibit 2, Tab 2.
[11] Exhibit 1, Tab 14 and Exhibit 2, Tab 2.
[12] T 7.
[13] T 7, 11 – 12.
[14] Exhibit 1, Tab 15.
[15] Exhibit 1, Tabs 14, 15 and 43 and Exhibit 2, Tab 2.

17. On 27 July 2010 the deceased attended a consultation with an IHMS nurse. He reported that he had episodes of feeling strange and dizzy but was otherwise well. He told the nurse he was feeling anxious and concerned as he had been told he had an enlarged heart. The deceased was reassured that his blood pressure reading was normal but he was was advised to cut down his smoking. He indicated that he had reduced his smoking since his last medical visit. He was given a note by the nurse to present in order to return to the clinic if he felt strange again.[16]

18. On 28 July 2010 the deceased was assessed as fit to travel to Curtin IDC. During consultation with IHMS staff the following day he reported ongoing dizziness that worsened on standing. No GP was available that day but it was noted that he already had a GP appointment for the following day and the deceased indicated he was happy to wait.[17]

19. On 30 July 2010 the deceased attended an appointment with another IHMS GP, Dr Christine Okello. Dr Okello understood the appointment was made due to his reports of ongoing dizziness. However, when Dr Okello saw him the deceased reported feeling well. His blood pressure and pulse were normal and had improved since his consultation with the clinical nurse the previous day. The deceased advised that he had not experienced further episodes of dizziness or shortness of breath and he showed no signs of ankle oedema. Dr Okello noted that the chest x-ray taken as part of his Health Inductions Assessment indicated that the deceased had a mildly enlarged heart but a clinical examination indicated no abnormalities or signs of heart failure. The general impression was that the deceased was well and he did not display any clinical signs of heart disease.[18]

MEDICAL CARE AT CURTIN IDC

20. On 2 August 2010 the deceased was transferred to the Curtin IDC and the following day he attended an appointment with an IHMS nurse, Registered Nurse Angela Knight. Nurse Knight noted the deceased was tachycardic (meaning his heart was beating fast) and the deceased told her that he had been told he had a large heart, which was reflected in the medical records. Given his medical history she scheduled an appointment with the IHMS GP for the next day.[19]

[16] Exhibit 1, Tabs 14 and 43 and Exhibit 2, Tab 2.
[17] Exhibit 1, Tab 43 and Exhibit 2, Tab 2.
[18] Exhibit 1, Tabs 14 and 17 and Exhibit 2, Tab 2.
[19] Exhibit 1, Tabs 18 and 43 and Exhibit 2, Tab 2.

21. On 4 August 2010 the deceased attended the GP appointment with an interpreter and saw Dr David Millar. The deceased told Dr Millar that he had reduced his smoking from 60 cigarettes per day to 15 per day but still required advice about ceasing smoking. He also indicated he was concerned about his reported enlarged heart. Dr Millar noted that the deceased's heart sounded normal and his chest was clear. At the end of the appointment Dr Millar ordered an electrocardiogram (ECG) as well as a further chest x-ray and full blood examination and iron levels.[20] The blood samples were taken that day and it seems that Registered Nurse Wendy Ackers also did the ECG that day and she believes there were no abnormalities from her basic knowledge of reading an ECG.[21] Although one expert suggested that the ECG results were possibly abnormal, I accept the conclusion of Dr Davis that the results of the ECG recording were normal and not suspicious, consistent with the view formed by Nurse Ackers.[22]

22. On 9 August 2010 the deceased attended an appointment with an IHMS nurse to receive his medication for his insomnia. The next day he was taken to Derby Hospital and underwent the scheduled chest x-ray.[23]

23. On 16 August 2010 the deceased attended another appointment with Dr Millar to discuss the chest x-ray results. Dr Millar reviewed the x-ray and noted that the x-ray did not show any effusion but there were signs of old injuries to the deceased's ribs. The deceased's heart size was reported in the chest x-ray report as in the upper limits of normal. The deceased reported during the medical review that he was still having difficulty quitting smoking and was smoking from 25 cigarettes per day, so Dr Millar referred him to the Quit Program on site. Dr Millar does not recall the deceased describing any symptoms such as chest pains or shortness of breath that might have indicated the presence of an underlying cardiac problem. Dr Millar also noted that at 30 years of age, he also would not have considered this to be likely in the deceased.[24] Dr Millar subsequently reviewed he blood test results, which were normal.[25] He did not receive the ECG report, although given Dr Davis' indication that the results were normal, it would not have assisted him if he had.[26]

[20] Exhibit 1, Tabs 19 and 43 and Exhibit 2, Tab 2.
[21] Exhibit 1, Tab 20.
[22] T 22; Exhibit 1, Tab 9, p. 2 and Tab 10, p. 1.
[23] Exhibit 1, Tab 43 and Exhibit 2, Tab 2.
[24] Exhibit 1, Tabs 19 and 43 and Exhibit 2, Tab 2.
[25] Exhibit 1, Tab 19.
[26] T 22; Exhibit 1, Tab 19.

EVENTS ON 21 - 22 AUGUST 2010

24. The deceased shared a room at Curtin IDC with Mr Syed Hussaini. They had known each other since 2006 and in the four months prior to the deceased's death Mr Hussaini reports that they had become "almost like brothers."[27] Mr Hussaini had noted that over the four month period he could see that the deceased was not well and in particular it looked like his face was swollen and he had put on weight.[28] He also complained to Mr Hussaini on at least two occasions that he was short of breath.[29]

25. On Saturday, 21 August 2010 the deceased and Mr Hussaini woke up at about 3.00 pm, presumably after having an afternoon nap. The deceased left their shared room and then brought back some tea, which they drank together. At about 3.30 pm the deceased and Mr Hussaini decided to go to the gym.[30] The deceased had told Mr Hussaini a couple of weeks previously that his doctor had told him it was okay to exercise.[31] On that particular day the deceased had appeared to be feeling a bit down and was worried for his family, but he did not complain that he was feeling unwell at all.[32]

26. The deceased had previously signed an acknowledgment that he had been provided with an induction on how to use the gym equipment in a correct and safe manner and was prepared to abide by the gymnasium code of conduct.[33]

27. Mr Hussaini and the deceased walked to the gymnasium and then Mr Hussaini began to lift weights while the deceased coached him. The deceased also lifted a few weights, although not as many as his companion. The deceased stayed in the gymnasium with Mr Hussaini for approximately half an hour, during which time he also trimmed his moustache. The deceased then told Mr Hussaini he was going to return to their room and left the gymnasium.[34]

28. Sometime after 4.30 pm a male person approached a group of volunteer aid workers and detainees who were participating in a beading and weaving programme. The male told the two female volunteers that he had seen somebody passed out and pointed in the direction of the toilet block. The two women ran to the toilet block and found a male lying on his back on the bottom of the

[27] Exhibit 1, Tab 21 [6].
[28] Exhibit 1, Tab 21 [8].
[29] Exhibit 1, Tab 21 [9].
[30] Exhibit 1, Tab 21 [11] – [13]
[31] Exhibit 1, Tab 21 [15].
[32] Exhibit 1, Tab 21 [23].
[33] Exhibit 1, Tab 12.
[34] Exhibit 1, Tab 21 [16] – [17].

steps, who was later identified as the deceased. He was dressed only in underpants and had a towel and toiletry items lying next to him. There was vomit coming from the right side of his mouth. One of the volunteers then set off her portable duress alarm and within seconds some Serco officers arrived.[35]

29. In total nine Serco officers attended. The officers received the initial call at approximately 4.40 pm and the first officers arrived within 15 to twenty seconds of receiving the call.[36]

30. IHMS medical staff were requested to attend urgently and two of the Serco officers commenced providing first aid to the deceased while waiting for the medical staff. They noted signs of shallow breathing and so they placed him in the recovery position and cleared the deceased's airways of vomit. The medical team, comprising of two registered nurses, arrived within a few minutes and took charge of the deceased.[37]

31. On arrival at the scene IHMS staff noted that the deceased was in the recovery position and unresponsive. There were no objective signs of life, with both of the deceased's pupils fixed and dilated, no spontaneous breathing and no palpable pulse. His skin had a mottled appearance and there was deep cyanosis of his lips, suggesting a sustained period of time had elapsed since he stopped breathing. The deceased's Glasgow Coma Score (GCS) was rated as only 3 out of 15 at that time. After CPR was commenced the deceased was seen to be attempting to breathe on his own but his breathing was intermittent.[38]

32. An ambulance attended at the detention centre at approximately 5.20 pm. Ambulance officers used a defibrillator, which showed ventricular fibrillation, for which he was defibrillated. He was subsequently found to have a bradycardia (slow heart rhythm) with no discernible output. Ambulance staff followed with three doses of adrenaline. At this stage breathing sounds were heard. At approximately 5.50 pm the deceased left Curtin IDC and was taken by ambulance to Derby Hospital Emergency Department, accompanied by one of the IHMS nursing staff and a SERCO officer, with CPR was continued en route.[39]

33. The deceased arrived at Derby Hospital at approximately 6.30 pm. A doctor from the hospital entered the ambulance and examined the deceased and noted the deceased had a heartbeat and palpable pulse and was making some spontaneous

[35] Exhibit 1, Tab 22 [5] – [12] and Tab 23.
[36] Exhibit 1, Tab 25.
[37] Exhibit 1, Tabs 24 and 25.
[38] Exhibit 1, Tab 14 and Exhibit 2, Tabs 2 and 27.
[39] Exhibit 2, Tabs 2 and 27.

respiratory effort. The medical team removed the deceased from the ambulance and he was taken into the Emergency Department for further medical treatment. The deceased was intubated and ventilated and also given antibiotics.[40]

34. Later that evening the deceased was airlifted by the Royal Flying Doctor Service to Sir Charles Gairdner Hospital (SCGH) in Perth. At the time he was transferred from Derby Hospital his prognosis was very poor.[41]

35. The deceased was admitted to the Intensive Care Unit at SCGH at 7.50 am on 22 August 2010. It was noted on arrival that he was intubated and ventilated but had been significantly hypoxic, acidotic and hypotensive for some period prior. Various investigations were performed at SCGH, including a chest x-ray and CT scan of the head. The conclusion from the CT was that the appearances were in keeping with anoxic brain injury with cerebral oedema and uncal/tonsillar herniation.

36. Despite the attempts at resuscitation and maintenance of life-support the deceased continued to display signs of severe metabolic acidosis, haemodynamic and respiratory failure and continued to show signs of severe hypoxic brain injury. In view of the lack of response and the futility of ongoing treatment it was decided not to escalate treatment any further and he died at 3.20 pm on 22 August 2010.[42]

CAUSE AND MANNER OF DEATH

37. On 26 August 2010 Dr Gerard Cadden, a Forensic Pathologist, conducted a post-mortem examination on the deceased. Dr Cadden noted the deceased's history of collapse at the detention centre and that during the deceased's subsequent hospitalisation enlargement of his heart was identified.[43]

38. At post mortem examination enlargement of the deceased's heart was confirmed with extensive scarring over the left ventricular surfaces. Within the major vessels supplying the left coronary system (left anterior descending coronary artery) severe disease was evident with virtual total blockage. The changes within the one vessel were severe.[44]

[40] Exhibit 1, Tab 27 and 37.
[41] Exhibit 1, Tab 37.
[42] Exhibit 1, Tab 40.
[43] Exhibit 1, Tab 5.
[44] Exhibit 1, Tab 5.

39. Marked pooling of fluid within the lungs and chest cavity was also evident. The fluid appearances within the lungs were in keeping with acute cardiac failure.[45]

40. Toxicology analysis results showed a variety of medications at therapeutic to high therapeutic levels.[46]

41. Neuropathology examination of the deceased's brain noted cerebral swelling, which was in keeping with the head CT examination conducted in hospital prior to his death.

42. At the conclusion of the post mortem examination Dr Cadden formed the opinion that the cause of death was acute cardiac failure in association with severe ischaemic heart disease secondary to severe coronary atherosclerosis.[47]

43. Dr Davis is a cardiologist who has been specialising in cardiac electrophysiology (heart rhythm disturbance management, which includes ventricular arrhythmia and sudden cardiac death) for over 30 years.[48] Dr Davis reviewed the deceased's medical records, including the post mortem examination records, and formed the opinion that the deceased died from complications of a large anteroseptal myocardial infarction with aneurysm formation due to subtotal occlusion of the proximal left anterior descending coronary artery. This was superimposed on severe coronary atherosclerosis. In Dr Davis' opinion, the deceased most likely suffered the infarct at least 72 hours prior to his out-of-hospital cardiac arrest due to ventricular fibrillation on 21 August 2010 (and sometime between 4 August and 18 August 2010). Dr Davis explains that ventricular fibrillation is a not uncommon, late complication of large volume myocardial infarction. The cardiac arrest led to multi-organ failure, including pulmonary oedema and hypoxic brain injury and his subsequent death within 24 hours.[49]

44. Dr Cadden and Dr Davis' conclusions are consistent, in that the deceased died from an acute cardiac event on the background of severe coronary artery disease. Dr Davis' opinion provides a more expansive explanation of the mechanism of death and the events that led to the eventual acute event on 21 August 2010.

45. For simplicity's sake, I adopt the conclusion of Dr Cadden as to the cause of death. It follows from the cause of death that the manner of death was by way of natural causes.

---

[45] Exhibit 1, Tab 5.
[46] Exhibit 1, Tabs 4 and 6.
[47] Exhibit 1, Tabs 5 and 7.
[48] Exhibit 1, Tab 10, p. 1.
[49] Exhibit 1, Tab 10, p 1.

QUALITY OF SUPERVISION, TREATMENT AND CARE

46. Under s 25(3) of the Act, where the death is of a person held in care, the coroner investigating the death must comment on the quality of the supervision, treatment and care of the person while held in that care. That obligation does not apply in relation to the deceased's case, but it is desirable that I make such comments. I have found that the treatment and care provided to the deceased was appropriate and of a reasonable standard in the relevant circumstances. My conclusion relies heavily upon the expert evidence of Dr Davis.

47. As noted above, the deceased died as a result of an acute cardiac arrest on the background of severe coronary artery disease. The main questions posed at the inquest were:

    i. whether his coronary artery disease should have been identified while he was receiving medical treatment in detention, prior to his death?, and
    ii. if it had been identified, was his death preventable?

48. As well as hearing oral evidence from Dr Davis on this issue, an expert report was also provided by Dr Peter Winterton, a Specialist Family Physician and Clinical Associate Professor in the Departments of Child Health and General Practice at Notre Dame University.[50] I have had regard to Dr Winterton's report as well as Dr Davis' evidence in reaching my conclusion.

49. Dr Cardon, who saw the deceased at Christmas Island IDC on 21 July 2010, noted that even in a smoker, "it is uncommon to have advanced coronary disease at 30 years of age and very uncommon to have coronary insufficiency without significant chest pain."[51] The deceased also exhibited no definitive physical or radiographic signs of heart strain or failure, or pathologies that commonly follow from advanced coronary artery disease.[52] Dr Winterton expressly agreed with Dr Cardon's comments in this regard.[53]

50. Dr Davis noted that whilst it is rare for a young man to die from coronary artery disease, it "is certainly not rare in a heavy smoker (60 cigarettes per day)"[54] although it is still unusual in a man of his age.[55] Dr Davis also noted we know nothing of the deceased's other risk factors, in particular family history and

[50] Exhibit 1, Tab 9.
[51] Exhibit 1, Tab 15.
[52] Exhibit 1, Tab 15.
[53] Exhibit 1, Tab 9, p. 2.
[54] Exhibit 1, Tab 10, p. 1.
[55] T 20.

lipid profile, although just the deceased's heavy smoking on its own placed him in a particular risk group for sudden cardiac-related death.[56]

51. Dr Davis noted that the deceased had been told to reduce his smoking and was referred to the Quit program by Dr Millar on 16 August 2010. Dr Davis observed that if the deceased had followed the advice and stopped smoking completely, his risk of sustaining myocardial infarction would have reduced immediately. At the inquest Dr Davis explained that this is because smoking is a major factor in clots forming in arteries, which is the mechanism of a heart attack, and even smoking a few cigarettes makes a clot form more easily and be more likely to occur. The risk of having a heart attack for a smoker is almost halved shortly after the person stops smoking, due to the reduced risk of a clot forming in an artery, although there remains a long-term impact from smoking that cannot be undone overnight.[57]

52. Other than that missed opportunity to reduce the deceased's risk of a heart attack, Dr Davis did not suggest there were any other steps that ought to have been taken by any person, given what was known at the time. Having reviewed all of the deceased's medical records, Dr Davis "found no evidence that the deceased had ever complained of any symptoms which would draw attention to the possibility that he had significant coronary disease which, if identified, could have been treated appropriately."[58] In order for his cardiac condition to be treatable, there needed to be symptoms and signs raising red flags, particularly in someone so young, leading to specific investigations such as exercise stress testing or CT coronary angiography. In this case, there were no such indicators.[59]

53. Dr Davis explained at the inquest that the deceased's symptoms of low blood pressure and light-headedness were not surprising in a man who was very underweight and were not a sign of heart disease.[60] The suggestion of cardiomegaly (enlarged heart) was also unlikely to be accurate, given it was noted on a chest x-ray, which is not a reliable way to assess heart size.[61]

54. Dr Davis expressed the opinion that the attention given to the deceased by nursing and medical staff before 21 August 2010 was "exemplary"[62] and he could not find any fault in the

[56] T 20; Exhibit 1, Tab 10, p. 1.
[57] T 20.
[58] Exhibit 1, Tab 10, p. 2.
[59] Exhibit 1, Tab 10, p. 3.
[60] T 21.
[61] T 22.
[62] Exhibit 1, Tab 10, p. 2.

treatment provided.[63] From the evidence available, Dr Davis considered that all appropriate investigations were undertaken and it was even unusual for the second chest x-ray and ECG to have been done in the circumstances.[64]

55. If the deceased had exhibited symptoms of coronary disease or even an acute heart attack at an earlier stage, before significant damage was done, then there were treatments available, ranging from aspirin to dissolve clots to surgical procedures such as angioplasty.[65] However, because the deceased was asymptomatic, even after he had a myocardial infarction, there was nothing that could reasonably have been expected to be done by the nursing and medical staff who were treating him.

56. Dr Davis also agreed that it is possible that further investigations, such as a standard exercise stress test, might not have been able to identify the extent of the deceased's coronary artery disease.[66]

57. As to his medical care after his cardiac arrest, Dr Davis also found the response of nursing staff was rapid and exemplary and stated it is testament to the quality of the CPR provided that the deceased survived to be transferred to Derby Hospital and then on to Perth.[67]

58. Dr Davis explained that the data reveals that the prognosis for people having a cardiac arrest out in the community is "grim,"[68] with only about 10% surviving and only 8% surviving with good brain function.[69] Even in optimal circumstances, for example if the collapse occurs in a hospital where there is access to experienced people able to do resuscitation quickly, the survival outcome is still less than 50%, so the outcome for the deceased may not have changed even if he had been taken to hospital for treatment earlier.[70]

CONCLUSION

59. The deceased was a thirty year old Afghan man who came to Australia by boat in the hope of seeking asylum. Although he was still a relatively young man, the deceased had developed severe coronary artery disease, due predominantly to his history of

[63] T 19.
[64] T 22, 25; Exhibit 1, Tab 10 p. 3.
[65] T 23 – 24.
[66] T 24.
[67] Exhibit 1, Tab 10, p. 2.
[68] T 23.
[69] T 23.
[70] T 23; Exhibit 1, Tab 9, p. 3.

heavy cigarette smoking (although other unknown genetic factors may also have contributed).

60. The deceased was asymptomatic for his condition and seemingly unaware of the perilous state of his health. Standard medical care also did not identify any warning signs. He was advised to stop smoking, as part of general health advice and in the context of a possibly enlarged heart. If he had succeeded, his risk of a heart attack would have been significantly reduced. Unfortunately, although the deceased did take active steps to reduce his cigarette consumption, he was unable to cease smoking altogether before his death.

61. Sometime between 4 and 18 August 2010 the deceased developed a clot in his artery, which blocked the artery and stopped blood travelling to his heart. This led to permanent damage to his heart muscle, known as a myocardial infarction or otherwise more commonly known as a heart attack. It is not clear that the deceased was even aware this had occurred. On 21 August 2010 the deceased went into cardiac arrest due to ventricular fibrillation as a complication of the large myocardial infarction. Despite resuscitation and medical treatment in hospital, he had sustained irreversible damage to his organs and brain and he died the following day.

62. It is a very sad event that a young man died suddenly far from home and his family after surviving what must have been an arduous journey by boat in the hope of a better life in Australia. However, I do not find that his detention played any part in his death. I also find that the medical care provided to him, both before and after his cardiac arrest, was of a high standard, and as good, or better than would have been available in the community.

S H Linton
Coroner
10 October 2016